

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

22957

1. PLACE OF DEATH

County.....
Township.....
City St. Louis, Mo. (No.)

Registration District No. 791
1003
Primary Registration District No. Sanitarium

File No.
Registered No. 6381
St. Ward)

2. FULL NAME

John Dill

(a) Residence. No. 1041 Victor St., 13 Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 39 yrs. - mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Widowed

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 10, 1871

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
58 4 1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Dinner
(b) General nature of industry, business, or establishment in which employed (or employer). Unknown
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY) Germany

10. NAME OF FATHER Adam Dill

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Barbara Weyfald

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY) Germany

14. INFORMANT William T. Gutter, M.D.
(Address) 5400 Arsenal St.

15. FILED JUN 13 1929 Ray Stark 71

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 11, 1929

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1925, to June 11, 1929, that I last saw him alive on June 11, 1929, and that death occurred, on the date stated above, at 5:45 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Trachea

(duration) 49 yrs. 2 mos. - ds. +

CONTRIBUTORY (SECONDARY) 49 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? No DATE OF.....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Clinical & lab.
(Signed) William T. Gutter, M. D.

6/12, 1929 (Address) 5400 Arsenal St.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Courcourdia DATE OF BURIAL June 4 1929

20. UNDERTAKER Benkuste Fred Co ADDRESS #234

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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REGISTER

